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Section 1115 Demonstration Waivers
Key Facts

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to waive certain requirements of federal Medicaid statute and regulation. Under the authority, the Secretary can permit a state to receive federal matching funds to operate its Medicaid program in ways not otherwise allowed under federal rules so long as the state's proposal promotes the key objectives of the Medicaid program. The authority is broad but not unlimited and the Secretary does not have the authority to waive, for example, the federal matching payment formula.

States can receive comprehensive waivers that make broad changes to benefits (typically to expand them), cost sharing, service delivery systems, and other ideas that states put forward, again with the primary objective of promoting the goals of the program. The Affordable Care Act (ACA) creates an additional Section 1115A waiver authority that establishes the Center for Medicare and Medicaid (CMS) Innovation to test, evaluate, and expand different service delivery and payment methodologies to foster patient-centered care, improve quality and slow cost growth in Medicare, Medicaid and Children's Health Insurance Program (CHIP).

Section 1115 waivers are approved and renewed through negotiations between a state and HHS. They are generally approved for an initial five-year period and must be renewed, typically in three-year increments. At any time during the life of the waiver, the state may submit, and CMS typically approves, amendments to the waiver to accommodate changes in state or federal law.

The federal government requires that the 1115 waiver be "budget neutral" over the life of the waiver. That means that the costs to the federal government for the populations and services to be covered by the wavier cannot exceed the costs for those populations and services that would have been covered in the absence of the waiver. The budget is established as follows:

- The State provides a 5 year historical "look-back" at the costs incurred for the populations and services it intends to place under the waiver;

- The State projects a 5 year forward trend rate for anticipated growth in these costs; the trend rate is negotiated with CMS and the Office of Management and Budget (OMB);
- The resulting projection of federal expenditures becomes the ñcapò for the federal contribution to the costs of the populations and services covered under the waiver.
- HOWEVER, this cap is projected on a per person basis and varies by eligibility category. Under this per capita cap, federal matching funds automatically adjust for enrollment levels but not for higher than projected per person costs.

Because the budget neutrality agreement projects a ñper personò (varying by eligibility category) projected expenditure, many states with comprehensive waivers have been better able to successfully budget for their Medicaid programs.

It should also be noted that many states with comprehensive waivers continue to take advantage of grant funding opportunities that arise in Medicaid during the life of their waivers; there is nothing in a waiver that penalizes a state or precludes applications for grant funds in Medicaid.

Two states, (Vermont and Rhode Island) currently have waivers that operate under aggregate caps. These caps place a total limit on federal spending for waiver-related expenditures and do not adjust for higher than projected enrollment or per person cost increases. Some people refer to these waivers as block grants; however, they are not block grants. The Secretary does not have the authority to waive the federal matching formula and both Vermont and Rhode Island must continue to put up their state share in order to draw down against their federal budget. This is not the kind of budget agreement that New Mexico will be pursuing; rather, the State will seek the more traditional per person agreement as described above.

As of April 30th of this year, 30 states and the District of Columbia were operating one or more Section 1115 Medicaid waivers. New Mexico currently has three Section 1115 waivers; two waivers authorize the State Coverage Initiative (SCI) program and one authorizes a provision in the Stateõs CHIP program.

Key Advantages of the Section 1115 Waiver include:

- Provides the state more flexibility in the design of its service delivery system in order to provide quality care for Medicaid recipients;
- Creates opportunities to expand access to certain services such as those provided under the DD and D&E waivers;
- Allows for more predictability in the budgeting process so that Stateõs have a more precise sense of anticipated costs; and
- Access to grant funding opportunities from the federal government remains in place.